

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-026444

6959

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6959

SL-31097 XC-577 976

1. PLACE OF DEATH FILED JUL 12 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MISSISSIPPI	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN: EAST PRAIRIE	
Length of stay in 1b 53 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.		d. STREET ADDRESS (If outside, give location) 211 HEMLOCK STREET	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WESLEY E. Middle SWITZER Last SWITZER		4. DATE OF DEATH Month 7 Day 2 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/11/94
9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY KENTON, OHIO	
11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JACOB J. SWITZER		13b. MOTHER'S MAIDEN NAME FRANCES A. BAKER	
14. NAME OF HUSBAND OR WIFE OLIVE L. SWITZER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of) YES WW-I	
16. SOCIAL SECURITY NO.		17. INFORMANT OLIVE L. SWITZER (WIDOW) SEE #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL METASTASIS PRIMARY CARCINOMA RIGHT LUNG Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 162.1	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. <input checked="" type="checkbox"/> VA attended the deceased from 5/10/63 to 7/2/63 and last saw him alive on 7/2/63 Death occurred at 11:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Robert R. Maginn ROBERT R. MAGINN (Degree or title) M.D.	
22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 7/2/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-5-63	23c. NAME OF CEMETERY OR CREMATORY East Prairie, Mo.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR Shelby Funeral Home, East Prairie, Mo.		25. DATE RECD. BY LOCAL REG. JUL 7 1963	
26. REGISTRAR'S SIGNATURE Earl Smith. M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.